South Carolina Department of Disabilities and Special Needs

**COMMUNITY RESIDENTIAL ADMISSION/DISCHARGE REPORT**

Consumer Name: _____ Consumer SSN: _____

DSN Board/Private Provider: _____

**Type of Action (check one)**

☐New Admission ☐Transfer ☐Discharge

**Action Restrictiveness (check one)**

☐More ☐Less ☐Equal

**New Admission**
(only complete for those individuals not currently receiving DDSN funded residential services)

Date Individual Placed on Critical Needs Waiting List: _____

**OR** Date Individual Placed on Priority I Waiting List: _____

Date of Proposed Admission: _____ Date Individual Expressed Desire to Be Served In Residential Program: _____

Proposed Residential Program (Name): _____ Type of Residential Program (e.g., CTH II): _____

Does Individual Have HCB Waiver Slot Assigned: ☐Yes ☐No

Proposed Funding Band: _____
(Include funding band change justification if different from standard funding band for type of placement)

**Consumer moving from "at home in the community" will be funded at Band G level for ICF/ID, CRCF and CTH II placements and at Band C level for SLP II, Band D for SLP I, Band E for CTH I and Band F for Enhanced CTH I placements unless otherwise justified.**

**Transfer**
(only complete for those individuals currently receiving DDSN funded residential services)

Date of Proposed Transfer: _____ Date Individual Expressed Desire for Transfer: _____

Proposed Residential Provider: _____ Proposed Residential Program (Name): _____

Type of Residential Program (e.g., SLP, CTH I, CTH II, ICF/ID): _____

Current Residential Provider: _____ Current Residential Program (Name): _____

Type of Residential Program (e.g., SLP, CTH I, CTH II, ICF/ID): _____

Current Funding Band: _____ Proposed Funding Band: _____

(Include funding band change justification if different from standard funding band for type of placement)

**Consumers moving from regional centers or alternative placements will be funded at Band H level for ICF/ID, CRCF and CTH II placements, Band C level for SLP II, Band D for SLP I, Band E for CTH I and Band F for Enhanced CTH I placements unless otherwise justified. Band C, D, E or F consumers moving to more restrictive placements will be funded at Band G levels unless otherwise justified.**

**Discharge**
(only to be completed for those individuals who will no longer be receiving residential services from the current Agency)

Date of Proposed Discharge: _____ Proposed Service Agency After Discharge: _____

Proposed Post-Discharge Service (e.g., no service, in-home services, SLP, CTH I, CTH II, ICF/ID): _____

Proposed Post-Discharge Funding Source (e.g., HCB waiver, state funded day supports, individual rehab supports): _____

**Rationale**

(Explain why the proposed admission/transfer/discharge is being recommended – can attach Program Team meeting minutes – must attach record of HRC approval for More Restrictive actions)

_____

**DSN Board/Private Provider Certification**
I hereby certify that the information contained in this report is accurate.

_____ _____
Executive Director Date

**DDSN Approval**

_____ _____
Assistant District Director Date

_____ _____
District Director Date

_____ _____
Director of Cost Analysis Date

**submit to DDSN District Office (Assistant District Director)**